CalPERS
Member Services Division
P.O. Box 942717
Sacramento, CA 94229-2717
FAX (916) 795-7878

DISABILITY ESTIMATE REQUEST

(THIS FORM IS TO BE USED BY THE STATE EMPLOYER ONLY WHEN THE EMPLOYER WILL BE GENERATING A DISABILITY APPLICATION ON BEHALF OF THE MEMBER)

THIS FORM IS NOT AN APPLICATION FOR RETIREMENT.

Please complete this form and fax or mail to the above address. The disability retirement estimate will be faxed or mailed to the address you indicate on this form. This estimate cannot be processed unless all information on this form is complete.

1. Employee Name (First) (MI) (Last)	**2. Social Security Number**
3. Employer Mailing Address	**4. Member Birth Date** Month / Day / Year / /
City **State** **Zip Code**	**5. Telephone Numbers** Work( ) Fax( )
6. Employer	

7. Last day on paid status Month / Day / Year / /	**8. Type of Estimate** ☐ Disability Retirement ☐ Industrial Disability Retirement	

9. Beneficiary Birth Date (if known)
Month / Day / Year

/ /

Relationship to member: _____

A. Has the member been married or in a registered domestic partnership for at least one year prior to the retirement date?
☐ Yes ☐ No

B. Does the member have any unmarried children who are under age 18 or disabled?
☐ Yes ☐ No